



VOICE OF THE DIABETIC

A SUPPORT AND INFORMATION NETWORK

The Diabetics Division of The National Federation of the Blind

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Page 1

Outlook Determines Outcome

by Denise J. Bradley



Denise J. Bradley, a long-time diabetic, tells of her struggles with diabetes and how her outlook changed to diligently taking care of herself by keeping her diabetes in control.

(Note: Denise teaches a course called "The Ups and Downs of Diabetes" through the University of New Mexico Continuing Education program. She has also written a book entitled *What Does It Feel Like to Have Diabetes: A Dair of Events in the Life of a Diabetic* which she says "looks at the emotional side of diabetes and is upbeat and inspiring".)

My outlook is powerful because it determines the outcome of my diabetes.

When my outlook was poor, my health was poor. And, when my attitude changed for the positive, so did my diabetes. I used to face the crisis

points of diabetes with resignation and defeat until I faced up to how I saw myself and my disease. This change of heart did not come easily or quickly however; it was a 20 year learning process.

My learning began in the summer of 1963 when I was 11 years old. It was the beginning of school vacation and, for weeks, I was tired, run-down and had little appetite. Unbeknownst to me or my family, I lost 40 pounds from dehydration during this time. I grew increasingly sick and finally lapsed into a coma just as the doctor diagnosed me as a juvenile, Type I, diabetic. It was traumatic for me to awaken in a hospital with needles bandaged to my arms.

A couple of days after starting on insulin and restoring my body fluids, I began to feel my energetic self again. And, being showered with attention helped me cope with being in the hospital for the first time. I received numerous cards, gifts and visitors over my two week stay.

With youthful enthusiasm and curiosity, I learned the new duties I would have to carry out as a diabetic. Everyone praised my bravery when I administered my first insulin injection. I was admired for the careful way I tested for urine sugar in a small glass test tube.

The hardest part for me, and the most vivid memory I have of that time, was the night my father read to me from a book on diabetes. He told me I would have to avoid eating sweets. "Does this mean I can't go trick-or-treating anymore?" I asked. When he said, "Yes", I cried myself to sleep. I was not just crying over candy. I was extremely close to my

identical twin sister, and Halloween was one of our favorite times of year to share. Part of me now saw diabetes as something to resent, for it was robbing me of one of my childhood pleasures.

The mixed signals were confusing. On one hand I felt special, on the other hand, I felt different. At a time when I identified so strongly with my peers, being different was not something I wanted to face.

Over the next many months, life with diabetes became routine for me and my family. As long as I ran and played, looked healthy, ate my vegetables and took my shots, diabetes didn't seem that hard to live with. But a year later, when I was in seventh grade, I had a severe insulin reaction which terrified my family. Although appearing to be conscious, I was actually in a blackout and had no awareness of my behavior, which was bizarre to say the least. I ran around our house throwing things into the air and banging on doors.

Regretably, none of us had been prepared for this. I was not having the typical signs of low blood sugar we had been warned about.

Although we all survived the episode, it was a critical event in my life as a diabetic. Naturally my family was worried this might happen again.

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Karen Mayry, President, 919 Main Street, Suite 15, Rapid City, SD 57701; Phone: (605) 348-8418

Ed Bryant, Vice-President, Editor, 811 Cherry Street, Suite 306, Columbia, MO 65201; Phone: (314) 875-8911

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Voice of the Diabetic is a national publication of the Diabetics Division of the National Federation of the Blind. It is read by those interested in all aspects of blindness and diabetes. We show diabetics that they have options regardless of the ramifications they may have had. We have a positive philosophy and know that positive attitudes are contagious!

News items, address changes and other correspondence should be sent to the editor.

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The Diabetics Division of the National Federation of the Blind

The Diabetics Division of the National Federation of the Blind (NFB) is a support and information network for diabetics in general, but especially blind diabetics. Many of our members have sustained at least one ramification of diabetes: blindness, amputation, nerve damage, heart problems, kidney disease, sexual dysfunction, etc. Others have experienced no chronic complications of the disease, but want to use our services, learn more about diabetes and be part of a caring support group. We, in the Diabetics Division of NFB, attempt to reach out to fellow diabetics who may be finding it difficult to cope with the problems that accompany diabetes.

The most far-reaching medium of our support network is our quarterly magazine, *Voice of the Diabetic*. Each issue of *The Voice* contains personal, candid stories written by diabetics, their friends, and anyone whose experiences with diabetes and its complications might be helpful to others traveling the same road. Our magazine is an upbeat outreach publication that emphasizes the importance of good diabetic control, diet, and especially independence. We show diabetics that they have options, regardless of what side effects they may have experienced. Research and medical news about diabetes, as well as a column which features medical questions answered by an insulin dependent physician, are popular columns. *The Voice* also features a "Recipe Corner" that lists diabetic exchanges.

The Voice regularly features a resource column of aids and appliances to help blind diabetics independently take care of their disease. Also, the Diabetics Division of the NFB compiles a list of aids and appliances which provides locations to obtain equipment for diabetic self management.

Membership in the Diabetics Division of NFB is a mere \$2.00 a year and includes a year's subscription to *Voice of the Diabetic*, in print or cassette. Our institutional and professional magazine subscription rate is \$8.00 per year. We encourage you to become a member of the Diabetics Division of the National Federation of the Blind and take an active role in our dynamic support network.

Committees presently in full swing and support for anyone with the need include the following: Amputations and Prevention, Insulin Pump, Legislative, Pancreas Transplantation, Resource Library, Resources (Aids and Appliances), Renal Failure: Dialysis and Kidney Transplantation, and Sexual Dysfunction/Male Impotence.

We are here to lend a helping hand, a thoughtful word of encouragement and answer many questions and problems as they arise.

For Further Information:

The Diabetics Division of NFB
Ed Bryant, Editor/VP
811 Cherry Street, Suite 306
Columbia, MO 65201
(314) 875-8911

For a complimentary copy of *Voice of the Diabetic* in print and/or cassette, contact the editor, Ed Bryant.

Your Doctor Has Been in an Accident

by Royanne R. Hollins



Royanne R. Hollins, Insulin Pump Chairwoman, Diabetics Division of the NFB, explains that doctors are human. "We need to treat them with tender loving care (TLC)."

surgery?

Recently, I had to do some real soul searching about my feelings and expectations from my physicians. I have been under the care of an ophthalmologist who is a retinal specialist for almost four years. During this course of time, my vision has been deteriorating, needing a significant number of laser treatments as well as a vitrectomy. I have proliferative diabetic retinopathy. Over the course of these treatments, surgery and continuous follow-up exams and keeping "watch" on my eyes, I have been taken care of exclusively by the same retinal specialist.

Recently, I experienced a significant change in my vision — things had gotten even worse. I phoned my eye doctor to discuss this matter and to possibly be seen by him right away. Upon reaching the receptionist I was told, "I'm sorry, but your doctor has been in an accident." Oh my gosh! My heart sank. What's going to happen now? Who will take care of

(Continued on page 3)

If you or a friend would like to remember the National Federation of the Blind in your will, you can do so by employing the following language:

"I give, devise, and bequeath unto National Federation of the Blind, 1800 Johnson Street, Baltimore, Maryland 21230, a District of Columbia nonprofit corporation, the sum of \$_____ (or _____ percent of my net estate" or "the following stocks and bonds: _____") to be used for its worthy purposes on behalf of blind persons."

Outlook

(Continued from page 1)

They constantly asked me if I was all right or if I was supposed to be eating between meals. At first the comments seemed concerned and loving, but after a while they came across as nagging accusations. I did not like being singled out for what I perceived to be negative.

My response was to start eating in private, away from the watchful eyes of others. I became a compulsive eater; a problem I would have for over 12 years. Eating was an emotional comfort for me, and I turned to it again and again. Before long I had gained 20 pounds. The saddest thing of all was that, along with the weight, came a lot of guilt and a loss of self esteem.

Throughout the next few years, it was drilled into me, even by medical people, that diabetics always got sick, they were slow to heal and that I could expect foot and eye problems. I heard often how unfortunate it was that I had diabetes, but that I was courageous in accepting it. So, accept it I did. I accepted that I was the one in my family who would always have health problems. I also accepted that all my problems were a punishment for my overeating. The outlook for me was dim, and the best thing I could do was find my identity in being a brave martyr.

Almost as a self-fulfilling prophecy, problems began to appear—numb feet, infections and eye complications. In my senior year, I developed retinopathy in both of my eyes. This did not alarm me because I still had good vision. As with other side effects, it was hard to look into the future and fear what *might* happen. Becoming blind was not even a possibility as far as I was concerned.

My ignorance about diabetes was immense. I think my doctors assumed I understood my disease because I never asked questions. Actually, I was too intimidated to ask any. I often lied about my urine sugars; hoping to conceal my overeating. I was amazed that no doctor ever confronted me. They acted as if my problems were inevitable rather than preventable. Meanwhile, I suffered in silence, too ashamed to ask for help.

During college, I was plagued with painful neuropathy in my waist and hips. Sometimes the burning and itching was so bad that I could not bear the feeling of fabric against my skin. My eyes hurt a lot from bouts of iritis, although my vision decreased slowly enough that I got used to each change as it occurred. No matter what the crisis, I would reach a new level of tolerance.

Following college graduation, I was legally blind within a year. It was

a relief for others' attention to be diverted from my diabetes to my eyes. There was stress in moving back-and-forth between the world of the sighted and the world of the blind. And yet, I was fascinated by the new way I related to the world, using my intuition and other senses to aid my failing vision. This was the first complication to have a positive effect on me as well. I began listening to Talking Books, many on philosophy and spirituality, and I would contemplate for hours why my life had proceeded the way it had.

It seemed every complication that came my way, I was able to adapt to or put up with. Thankfully, there came a turning point in my life. It started with a small, red spot on my toe that, within a couple of weeks, turned into gangrene. At first I was scared and nervous. Then I decided this was it. I could no longer sit back and passively accept what happened to my body. When the orthopedic surgeon announced that my foot might have to be amputated, I knew I could not allow this to happen.

I felt extremely motivated to get healthy. In my mind's eye I saw myself strong and healthy and walking on two feet. I kept this picture in my mind through a month of being in the hospital and four surgeries and my foot was saved. During the next five months I had to clean my foot several times a day. My diligence paid off. I saw the tissue grow back healthy and pink. When I took my first step in half a year, it was the most beautiful thing that had ever happened to me.

I was truly inspired by my foot's speedy comeback. Also, after not walking for so long, I appreciated walking and physically using my body, more than ever. I began exercising for the pure joy of it. I toned up quickly. My own efforts were paying off and I felt powerful. I was inspired to reduce the amount of fat in my diet. The pounds fell away. Most importantly, I began testing my blood four times a day with a home glucose monitor and keeping charts. It was the best thing I ever did for myself. Within a few months I became so healthy, it was almost unbelievable. Gone were the infections, the itching, the constant high blood sugars. In their place was a body able to heal itself and a happier me.

My attitude was totally changed. My outlook on diabetes and my future is bright. I can only get better. Diabetes is a challenge and the more I learn and observe, the higher my quality of life. My family, too, only sees good things for me. If problems come along, and they rarely do, I handle them in the best way I know how—keep testing my blood, exercise, eat right, and most of all, assume the best.

What? Oh no! How bad is it? Will he be all right? What is the prognosis? Will he be able to perform my

Legislative Agenda for the Blind of America



James Gashel, Director of Governmental Affairs, National Federation of the Blind, works diligently with Congress to improve the lives of the blind.

(Editor's Note: For further information contact: James Gashel, Director of Governmental Affairs, National Federation of the Blind, 1800 Johnson Street, Baltimore, MD 21230; telephone: (301) 659-9314.)

Legislative Agenda 1989

From: Members of the National Federation of the Blind
 To: Members of the 101st Congress
 Re: The Blind: Legislative Priorities for the First Session of the 101st Congress

One-half million people in the United States are blind, and fifty thousand Americans become blind each year. The lives of millions of others—friends, neighbors, family members, business associates and co-workers—(although not blind themselves) are nonetheless affected by blindness and its social and economic consequences. As a result, public policies and laws concerning the blind have a profound impact throughout our society.

The blind as a group share a unique struggle. If a blind person has proper training and opportunity, the physical loss of eyesight itself can be reduced to the level of a mere nuisance. Misconceptions about blindness, coupled with lack of good training and limited opportunities, are the real handicaps. Although most sighted people have had some contact with blindness, it is still largely misunderstood and continues to be more a problem of public attitudes than physical disability.

Public policies and laws that result from misconceptions about blindness or lack of information are often more handicapping to the blind than loss of eyesight itself. This is why we have formed the National Federation of the Blind (NFB). NFB is a private-sector resource of knowledge, encouragement and support for the blind and

for all people (blind or not) who seek greater freedom and opportunity for the blind. We are proud of our self-help traditions, philosophy and achievements. The vast majority of our members are blind. We join NFB through local chapters and state-wide organizations everywhere in the United States.

We are the voice of the nation's blind—the blind speaking for themselves. Our priorities for the first session of the 101st Congress express our assessment of current issues in need of solution to improve the lives of the blind of all ages:

(1) *Congress should amend the Federal Aviation Act of 1958 to assure fair treatment for the blind in air travel.* This request seeks enactment of legislation to make unmistakably clear the Congressional intent that persons who are blind may not be subjected to unfair and discriminatory restrictive seating practices of airlines. The "Air Carrier Access Act" (Pub. L. 99-435) already prohibits discrimination against "the handicapped" in air travel, but most airlines are still ignoring the law, which the Department of Transportation (DOT) has yet to enforce by regulation.

The airlines and federal authorities appear to have little regard for the law or the will of Congress. It is outrageous that blind people are still subjected to arrests when they take seats assigned to them by the airlines. Law-abiding blind citizens have been hauled off to jail for not accepting discriminatory orders of airline personnel. Yet, DOT enforcement authorities refuse to intervene to protect the personal liberties and safety of blind passengers. The fact sheet entitled "Air Travel Rights for the Blind" gives more details and suggests specific legislation that the 101st Congress should enact. There would be no cost to anyone, including the government and the airlines.

(2) *Congress should amend the Act of March 3, 1879, "To Promote the Education of the Blind" to give qualifying institutions a choice in selecting items to be purchased from the American Printing House for the Blind or from other suppliers.* This proposal seeks to modernize and improve options available for obtaining textbooks and educational materials for blind students. The American Printing House for the Blind (APH) is a private, nonprofit agency chosen by Congress 110 years ago to receive federal funds in order to manufacture and furnish instructional materials specially adapted for use by the blind. Under existing law the Printing House is the exclusive, federally funded producer of educational products for the blind.

In the years since 1879, other suppliers of books and devices have be-

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Your Doctor

(Continued from page 2)

me? Is he (my doctor) going to be all right? How bad is it?

We tend to become extremely dependent upon our doctors. I must admit that the majority of my initial thoughts were very selfish. I was thinking of me, myself and I. However, eventually those thoughts did turn to my doctor and his welfare.

The more I thought of my doctor and what he was going through, the more concerned for his welfare I became. I seized this opportunity to show him that I *cared* for him. I committed to sending him a get-well card of a very humorous and uplifting nature once every week, from the time he was still hospitalized to the time he was home recuperating. I made calls to his office, not to discuss my problems (even though they were continuing as such) but to get a status on his recovery.

In this particular case, my physician had been at his vacation home in the mountains alone. He saw that the roof needed to be cleared of some ice. He had gotten up on the roof and chopped away to no avail and got back down again. As he was walking around the house, ice and snow (about 200 pounds' worth) slid off the roof on top of him. He was completely buried except for one arm and his head. Once again, he was alone. His calls for help dissipated into thin air without being heard by anyone. It took him 35 minutes, great courage and miraculous strength to

dig out of the slide. He then crawled inside the house to call 911. The result: five broken ribs, a punctured lung and a badly dislocated shoulder. He then suffered complications of pneumonia and did not gain use of one arm for over three weeks. I'm happy to report he has recovered nicely and should be able to perform surgery again soon. He definitely has a new outlook on life, and for about the first 10 minutes after the slide, the question of his survival was utmost on his mind.

This experience has made me realize that our physicians are human, just as we, the patients are. They are vulnerable and mortal like all of us. They are not God and are not beyond human frailties and mistakes. Take some time to let your doctor know you care for him as a *person*. He will truly appreciate that showing of care and concern and will surely reciprocate.

Our doctors are extremely important to us. Our physicians are so much a part of our everyday lives and everyday survival. Sometimes those physicians are as important as, or more important than, our very own families. We work very hard to establish a good rapport with those physicians and learn to trust them in every way possible. We need to treat them with tender loving care (TLC), and sometimes give a little extra. I hope none of you will ever experience hearing those words, "I'm sorry, but your doctor has been in an accident."

Legislative Agenda

(Continued from page 3)

come available. Their products, in some instances, represent the latest and best technological advancements. Also, other producers of Braille books have been able to reduce prices below those charged by APH for producing comparable items. Purchasing demands for APH products were once centralized through state-wide schools especially set up for education of the blind. Now, however, with the integration of the blind throughout the educational system, the demands for materials are quite diverse. Purchasing from APH exclusively is increasingly inefficient and costly. All institutions are in need of expanded sources of supplies of materials at the lowest possible cost. The fact sheet entitled "Access to Education: Reforms Needed in Services to Blind Children and Youth" explains what Congress can do now to help provide more materials for the federal dollar while meeting the new demands.

(3) Congress should amend the Social Security Act to give blind persons the flexibility they need in choosing acceptable and desirable sources of post-secondary training and employment services. This request seeks enactment of legislation to allow blind persons to select, design and pursue the assistance required to become employed and self-supporting. Under existing law, beneficiaries of Social Security programs (and all other blind people seeking training and employment services) are blocked in most cases from obtaining this help through any agency other than the one agency designated to provide rehabilitation services to the blind in each state.

Existing law authorizes Social Security to reimburse the state agencies when a beneficiary achieves employment, but states are reluctant to participate substantially in this "results-oriented" program. Funding participants (rather than programs) would be a better option. That can be done by letting each beneficiary choose which agency or training sources will be most responsive. The beneficiary (not a government agency) is often in the best position to know which training sources can best meet the need. Under a plan which gives blind beneficiaries greater freedom to choose among providers for their training and employment programs, cost-effective reimbursement for services could be made to private agencies and training sources as well as to state rehabilitation agencies. The fact sheet entitled "Breaking the Monopoly: Expanding Choices in Rehabilitation for Blind Adults" gives more details and an outline of the specific legislative changes that the 101st Congress should enact.

Blind people are asking for your help in securing positive action by Congress in the areas outlined here. Legislative proposals to achieve these objectives are prepared and available for consideration by the

101st Congress. Many priorities confront this session of Congress, but the needs of the nation's blind must not be neglected in the legislative agenda this year.

We, of the National Federation of the Blind, stand ready to assist our representatives and senators to understand our needs and to take meaningful action to address them. In partnership with the National Federation of the Blind, each member of Congress can help build better lives for the blind both today and in the years ahead.

Fact Sheet Air Travel Rights for the Blind

A BILL: "To amend the Federal Aviation Act of 1958 to prohibit discrimination against blind individuals in air travel."

Sponsors to cosponsor: Contact Senator Hollings. Staff contact: Steve Palmer, Majority Staff, Committee on Commerce, Science and Transportation, (phone) 4-9350.

House members to cosponsor: Contact Congressman Traficant. Staff contact: Paul Marcone, Chief of Staff, (phone) 5-5261.

The Problem: Arbitrary restrictions on seating of blind passengers are a most common form of degrading discrimination against the blind in air travel. The restrictions are not the same for each airline but generally apply to seats near emergency exits. There is no way to know from airline to airline (or from flight to flight on the same airline) which seats are expected to be "off limits".

Airline personnel routinely humiliate and bully blind people for sitting in their assigned seats near the exits. Law-abiding blind passengers are even arrested and hauled off to jail for taking seats assigned to them by the airlines. Flight delays beyond two hours are common in these incidents, during which airline personnel incite anger in other passengers toward the blind. When police will not arrest a blind passenger (because sitting near an emergency exit is not a violation of the law), flights are purportedly "cancelled" just long enough to deplane everyone. Then the same flight is reboarded and dispatched without the blind passenger. Air transportation for the blind is thus denied.

Existing Law and Regulations: Section 404(c) of the Federal Aviation Act of 1958 (enacted by Pub. L. 99-435) already prohibits discrimination against qualified handicapped individuals in air travel. Proposed rules were issued last year, but the final regulations (required by law to be issued by January 31, 1987) have not yet been published.

DOT's proposed rules are the first step of a plan to legalize discrimination against the blind in air travel by means of restricted seating. The second step of the plan is being developed in secret by the Federal Aviation Administration (FAA) in a separate rule making process. The entire

procedure and approach is deliberately deceptive. On the one hand, DOT's proposed rule says that no one may be excluded from any seat on the basis of handicap unless otherwise determined by the FAA. The deception is that FAA's rule will require a seat restriction. Officials say that the rule will "not discriminate against the blind," but "sight will be required" for any passenger to be seated near an exit. FAA has never had a regulation to limit seat assignments of the blind before, and there is no present or known justification for a new regulation now.

Proposed Legislation: Congress should amend the Federal Aviation Act of 1958 to assure fair treatment for the blind in air travel. Identical Senate and House bills entitled "The Air Travel Rights for Blind Individuals Act" have been introduced by Senator Ernest F. Hollings and Congressman James A. Traficant, Jr.

The bill calls for inserting a new sentence at the end of paragraph (1) of section 404(c) of the Federal Aviation Act of 1958 as follows: "An air carrier shall not restrict seating in aircraft on the basis of the visual acuity of a passenger or the use by a passenger of a white cane, dog guide or other such means of assistance."

This measure would not interfere with the FAA's responsibility to require safe air travel. Criteria that have a safety-based justification could be used to support policies that exclude passengers from seats near emergency exits. Restrictions based on blindness or visual impairment have no safety basis and would therefore be prohibited.

Need for Legislation: This bill provides a clear-cut solution to a problem that must be addressed. In all of the history of air travel, blindness has not been a hazard. Some airlines have not excluded blind persons from seats near emergency exits. Others have done so. They have used the nondiscrimination law to convince the FAA to make rules to restrict seating of the blind.

Airline personnel admit that they cannot accurately determine passenger abilities (or disabilities) to act as required in emergencies. In many instances they do not challenge passengers who pose obvious safety problems for themselves and others. Excessive carry-on luggage, although hazardous, is routinely permitted by the airlines as a passenger convenience. Also, passengers who have already had too much to drink before they reach the plane are often seated near emergency exits without question. Once on board the aircraft, these passengers may continue to consume liquor while seated near emergency exits. By allowing and condoning this unsafe behavior, airlines and airline personnel are placing millions of air travelers at risk.

Some passengers who are now given seats near emergency exits have poor judgment and cannot act responsibly during evacuation procedures. Others will panic and may not act at all. Unknown heart conditions

are common but not visible in passengers given seats near emergency exit doors. These passengers have safety risks that the airlines knowingly accept or negligently do not attempt to identify. Instead they target the blind for exclusion.

The attempt to impose seat restriction regulations on the blind disregards the will of Congress expressed in Pub. L. 99-435 and its underlying legislative history. The statute, which was intended to remove unfounded limitations on the blind, is being turned on its head and used against the blind by the airlines. FAA's behind-the-scenes rule-making proceeding represents an aggressive attempt by the airlines to legalize discrimination. Congress should resolve this issue in favor of safe and discrimination-free air travel by passing "The Air Travel Rights for Blind Individuals Act."

Fact Sheet Access to Education: Reforms Needed in Services to Blind Children and Youth

Background: The American Printing House for the Blind (APH) is by law the only federally funded supplier of instructional materials and equipment for the blind in elementary and secondary education. The funds annually appropriated directly to APH are used to produce textbooks in Braille and large type versions. Certain types of adapted equipment, educational materials and supplies are also provided. This has been the case since 1879 when APH first began manufacturing books for the state-wide residential schools for the blind that existed at that time.

This year there are about 4,000 blind or visually impaired youngsters attending elementary and secondary schools and another 4,000 blind persons in adult programs. Only a fraction of the students enrolled in elementary and secondary schools attend state residential schools. The vast majority are taught in their home communities. The textbooks they need are selected locally. Collaboration by state schools to supply the same books for each state at all grade levels is no longer possible.

Existing Law: The Act of March 3, 1879, entitled "An Act To Promote the Education of the Blind," first granted federal financial support to APH for manufacturing and furnishing books and other materials specially adapted for instruction of the blind. The law in its present form has a "such sums" authorization, with an actual appropriation of \$5,345,000 for FY 1989. At the beginning of each year, APH counts the number of blind students attending public and private nonprofit institutions for the education of the blind in the United States. These census figures are then used by APH to establish each institution's allotment for books and materials from APH during the ensuing fiscal year. Some of the federal dollars are used for research and development activities, and a small amount goes

for advisory services. The current appropriation provides each institution with an allotment of approximately \$111 per student.

The situation with respect to producers of books and educational devices for the blind has dramatically changed since 1879. One hundred years ago the American Printing House for the Blind was the only major producer. Today there are at least one half dozen other sources of books and materials which are at least as effective as APH. Some of them offer materials at lower costs and some offer products which APH does not supply. If blind students are to have the benefit of the best and the most for the dollars, then the 100 year old monopoly of APH must be eliminated. Examination of the continued use of APH as a single supplier is now urgently required.

Proposed Legislation: Congress should amend the Act of March 3, 1879, "To Promote the Education of the Blind" to give qualifying institutions a choice in selecting items to be purchased from APH or other suppliers. The amendments being proposed would maintain APH as a primary manufacturing facility and central clearing house of information about available books and materials. However, if an item meeting a qualifying institution's requirements is available from a source outside of APH, the federal funds provided through APH would have to be used for any purchase, at the option of the qualifying institution. Under existing law as described, the federal funds can only be used for products that APH manufactures or sells directly. The appropriation cannot be used to buy products from other suppliers. This provides a strong incentive to the institutions not to purchase items from other suppliers, even though products that more nearly meet the need (or better fit within the institution's budget) might be available somewhere else. Also the present situation encourages high prices and inefficiency at APH, as is almost always the case with monopolies.

Improvements Needed: Equal access to education for blind persons means having the books and materials necessary to compete and learn. APH has provided these items responsibly for many decades. However, changing demands require changing approaches. Increasingly, it is necessary to expend federal dollars to obtain quality materials at the most favorable price possible. Faced with competition, APH may not be the lowest priced book producer in all instances. For example, the Library of Congress, National Library Service for the Blind and Physically Handicapped, buys large quantities of Braille and recorded books and magazines from several manufacturers, including APH. But the prices charged by APH for Braille book production currently exceed those of all other suppliers. Like APH, all of the other suppliers are nonprofit, but unlike APH, none of them receives a federal appropriation. Prices charged

by APH are usually not the lowest among competing suppliers.

In 1879, APH was the only producer of instructional materials for the blind, and there were a relatively small number of schools needing these items. Now there are thousands of schools with varying demands for materials. The schools need more materials at less cost. They also need the new devices to aid the blind, representing the most up-to-date applications of modern technology that are being made by a growing number of small nonprofit and profit-making groups. Costs for these items are quite favorable, and in some instances unbelievably low. Some of the more exciting innovations include pocket-sized computers that talk, large type display terminals and braille output devices. Communications technology using computers now makes possible the cost-effective production of Braille books to meet individual demands. These developments and more have happened so rapidly that APH as a single supplier cannot hope to keep pace and provide in-house the most up-to-date items for everyone. Therefore, the demand could better be met by permitting qualifying institutions to use the federal funds available to obtain products from APH and other sources. This expansion would be a modest improvement in the law, would save federal dollars, would increase the number and type of materials available and pose no administrative problems. It is a cost-effective approach that Congress should now enact.

Fact Sheet

Breaking the Monopoly: Expanding Choices in Rehabilitation for Blind Adults

A BILL: "To amend titles XVI and II of the Social Security Act to promote the rehabilitation of blind beneficiaries under the SSI and OASDI programs, and to assure that the blind receive the most appropriate employment and training services which are available by permitting them to select the agencies to which they will be referred for such services."

Background: Federal support for rehabilitation of the disabled began in 1920, but programs for the blind were not eligible to receive federal assistance until 1943. Current rehabilitation services include various forms of medical, social, recreational, vocational, educational and research-oriented programs that are intended to improve the living conditions and life styles of all disabled persons in America. Employment (once the principle focus of the law) is now one of many objectives. This shift in emphasis has taken attention and financial resources away from supporting the individual employment needs of the blind in favor of serving the broader disabled population. The result is that the employment goal is now subordinate. However, recreation, social services and even medical care needs will almost

all be met for the vast majority of blind people if they get suitable jobs with pay and responsibilities commensurate with their individual abilities.

Existing Law: The Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, authorizes most of the current federally supported rehabilitation programs. Recipients and beneficiaries of Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) can also obtain rehabilitation services (paid for with SSI and SSDI funds). Not counting the funds for rehabilitation provided by Social Security, almost 1.5 billion dollars in federal financial assistance is distributed to the states under Title I of the Rehabilitation Act. The designation of a specific state agency to serve the disabled and blind is a prerequisite for receipt by any state of its share of the federal funds. Titles XVI and II of the Social Security Act also require that SSI and SSDI beneficiaries must be served through the same state agency system.

Under these arrangements the designated state agencies control the money (and in many respects the lives) of blind people who are trying to become productive citizens free from government support. Options for most blind people to choose among sources of training are realistically nonexistent. This lack of a free choice for each blind person to obtain needed services from a public or private source that will meet his or her own individual needs is a major deterrent to effective, responsive training and employment services, leaving almost 80 percent of employable blind people largely outside of our nation's workforce.

Proposed Legislation: Congress should amend the Social Security Act to give blind SSI and SSDI beneficiaries greater freedom to choose and design their own training and employment programs. A bill to accomplish this objective has been introduced in the House by Congressman Harold Ford. It presents a natural alternative to the present Social Security funding arrangement by allowing recipients of SSDI or SSI benefits to designate for themselves individually selected agencies, public or private. Under the bill, each blind beneficiary could choose a rehabilitation agency to provide services directly or obtain services from other programs. This approach (funding the participants and letting them choose their programs) would give each person a wider selection of relevant training and employment opportunities.

Since most blind people who are not employed receive either SSDI or SSI cash benefits, they would be immediately eligible under the bill to obtain individually needed training and job-related assistance. A beneficiary could continue with a rehabilitation program under the existing state agency structure. Alternatively, with the help of an individually chosen agency, a beneficiary could obtain training and employment services through a personally selected pro-

gram. In either case SSI or SSDI funds would eventually pay the costs as is now done through state rehabilitation agencies only. The outlays from the Social Security funds would not be increased.

Need for Legislation: Expansion of the Rehabilitation Act to support a broader range of services (including those of a social, recreational and independent living nature) has brought about demands for training and employment services for the blind which the single state agency system is ill-equipped to meet. The program just described would be a natural adjunct to the current structure. It would leave the existing funding arrangements and services under the Rehabilitation Act intact with all of the present financial support. The advantage would be greater selection of relevant services not limited to those available through assistance by a single agency in each state. State boundaries (and limits on out-of-state expenditures) would not prevent finding the best program for each individual. Under the improved program a source of funding (not tied to any state or any agency) would be available for anyone who wanted to exercise a free choice.

By stimulating competition among agencies to make their philosophies and programs attractive to potential participants, funding through Social Security would create a healthy, new environment of services full of new opportunities and vitality. In addition, Social Security funds paid to achieve training and employment goals would reduce demands for continuing cash outlays from the SSI and SSDI programs. This is a cost-effective approach that Congress should now enact.



Ask Dr. James

by Ronald James, M.D.



Ronald James, M.D., long-term insulin dependent diabetic, directs Midwest Diabetes Treatment and Education Center, Columbia, MO. Dr. James is also the Medical Director of the Central Missouri Diabetic Children's Camp, Inc.

(Note: If you have any questions for Dr. James, please send them to the editor. The only questions Dr. James will be able to answer are the ones used in his column.)

I want to know why cigarette smoking can damage my body. Is it more important, as a diabetic, not to smoke?

It is well known that smoking greatly increases the chances of developing lung cancer and emphysema, thus damaging one's body. In addition, it is a risk factor that increases the chances of developing arteriosclerosis, called hardening of the arteries. This in turn leads to a) poor circulation in the legs and feet which can result in gangrene and even amputation, b) coronary artery disease that may cause heart attacks, and c) poor circulation to the head called cerebrovascular disease which may produce strokes. Heavy smoking doubles the death rate due to these problems. Diabetes alone is a risk factor in producing arteriosclerosis. Smoking increases this risk even further, thus making the diabetic even more vulnerable to this problem. Some believe smoking increases the risk of developing diabetic eye disease, called retinopathy. Although it is important that no one smoke, for these reasons it is even more important that the diabetic not smoke.

I plan to marry soon and want to know if I can safely take the contraceptive pill?

I still believe marriage is a good institution. Oral contraceptives are

probably the most effective form of temporary birth control. Although they have certain well known side effects, in many cases these are less than the risks of pregnancy itself. On the other hand, it must be recognized that in the diabetic oral contraceptives cause a 3 fold increase in blood pressure and a 37% increase in blood triglyceride (fat) levels, both of which are risk factors for coronary artery disease. After the age of 35 the diabetic who takes oral contraceptives has a 4 fold risk of having a heart attack or stroke. The risk is also greatly increased if she smokes. Therefore I feel that oral contraceptives can be used with reasonable safety by the diabetic if she is less than 35 years old, doesn't smoke, doesn't develop high blood pressure or elevated triglyceride levels, and has good diabetes control. She should use them only when other acceptable and effective methods are not available.

My doctor tells me and other diabetic patients I know that one insulin injection daily is all that is needed. Is this true? Most of what I read seems to indicate that more than one shot per day is recommended.

Yes. I think that nearly all diabetics who need insulin will do better with at least two injections daily. With few exceptions there is no way one can adequately cover his/her insulin needs around the clock twenty-four hours a day with one injection. It is my feeling that the individual treated with one injection daily is more likely to develop the chronic complications of diabetes. Therefore, I strongly support the concept that almost all insulin taking diabetics should receive at least two injections daily. Many diabetes specialists agree with this view.

I am an older diabetic and realize that good foot care is important. What suggestions can you give me for taking care of my feet, and do you recommend custom-made shoes?

Recommendations for appropriate foot care can be found in many publications written for diabetics or obtained through the many diabetes education programs around the country. These recommendations, of course, deal with many factors such as keeping the feet clean, avoiding injury, keeping the nails and calluses appropriately trimmed, wearing seamless stockings or socks, and wearing soft shoes that protect the feet but do not cause undue pressure. One should observe his feet daily for injury, ulcers, redness, infection, drainage, or discoloration. If any of these are found or if there is pain, one should see his physician for fur-

ther evaluation and treatment.

It is my feeling that custom made shoes are of benefit only when the person's foot problem is such that he/she cannot wear ordinary shoes. This usually occurs when there is a deformity of the foot caused by the diabetes. Certainly there are those who could and do benefit from custom-made shoes.

I have a teenager with diabetes. What are the chances of my younger children developing the disease?

Since the genetics of diabetes is

not as well understood as we would like and since it may differ from one family to another, there is no sure way of predicting the chances of your younger children developing diabetes. However, population studies indicate that in general there is about a 1% chance any one of them will develop it by age 10, 3-5% chance by age 20, and 10% chance by age 50. Another way of looking at it is that they have a 5-20% greater chance of developing diabetes than if they did not have a close relative with diabetes.

A New Chance on Life

by Linda Bingham

Hello, my name is Linda Bingham, and I would like to tell you about my new life.

In May 1981 after 25 years of being a diabetic, I developed chronic renal failure. I started on continuous ambulatory peritoneal dialysis (CAPD) in July 1981. This was a very bad experience for me. I developed peritonitis two times by October 1981. (Editor's Note: CAPD is a form of dialysis in which waste products are removed through tubing that is placed through the abdomen wall. The tubing is connected to a sac, and the sac must be replaced several times daily. When reconnecting the tubing, it is important that the ends are not touched. If the tubing is touched, the chances of infection are greater as are the chances of developing peritonitis.)

To say the least, I did not adapt well to dialysis, as most diabetics do not. I think my worst problem was that I felt sorry for myself. I was 33 years old, divorced and had trouble taking care of my beautiful five-year-old daughter, Dawn. She was cared for by my cousin Nancy, and another good friend, Denny. So up until now, I was a diabetic of 25 years with chronic renal failure, loss of sight and high blood pressure.

After this, my life took a turn for the better. I was unable to get a kidney from a living donor, so on Oct. 29, 1981 I was put on the cadaver donor list. My nephrologist, Dr. First, from the University Hospital in Cincinnati, Ohio, started talking about a pancreas transplant. I was shocked. I did not realize they were being done. I agreed to a pancreas transplant and was told that if a pancreas was available when the kidney was, I would get both. I thought this was great. Then, on Dec. 10, 1981 at 4 a.m., my prayers were answered; there was a kidney for me. Within a matter of hours, I had a new kidney, pancreas and most of all, a new chance on life.



Linda Bingham, Pancreas Committee Chairwoman, Diabetics Division of the NFB, tells about how wonderful life is after having kidney and pancreas transplants.

I have not taken any insulin since my transplant. Just like all other people with transplants, I do take medication. I now take 5 milligrams Prednisone and 100 milligrams Imuran daily plus blood pressure medicine when needed. I feel good, and both my kidney and pancreas are working great.

I thank God for my wonderful doctors and surgeons: Dr. Alexander, my kidney surgeon; Dr. Munda, my pancreas surgeon; and Dr. First, my nephrologist.

Now over seven years later I am doing fine. I remarried in March 1982 to my good friend Denny whom I spoke of earlier. He adopted my daughter, and the three of us have a wonderful life together. I am thankful for the both of them.

I know many prayers were said in my behalf. The people in my church and their friends prayed for me daily. I know that only through the will of God, my family and an excellent medical staff was my life able to begin again and be so good.

Information for Families of Type I Diabetics

What is the test?

A test is being offered free of charge by the Joslin Diabetes Center and the Diabetes Clinical Research Unit, University of California, Davis, Medical Center. This test can determine if someone is likely to develop Type I diabetes several years in advance. In addition, this provides valuable information for research into the prevention and treatment of Type I diabetes. The simple blood test screens for the presence of antibodies being produced abnormally by the body's immune system. These antibodies destroy the body's insulin-producing islet cells, the beta cells. This destruction can continue for as long as nine years until the beta cells fall completely and diabetes develops.

Who should be screened?

At this time, the first-degree relatives (parents, children, brothers and sisters) of people with Type I diabetes

are high-risk candidates, about 2 percent will have a positive test. Suitable candidates also include the non-diabetic identical twin with a Type I diabetic twin mate. It is important to test first-degree relatives of all ages. While 50 percent of the cases of Type I diabetes occur by age 12, 40 percent develop the disease between the ages of 12-40 years and 10 percent do not become diabetic until after age 40. *This test is not for relatives of people with clear cut maturity-onset or Type II diabetes, also known as non-insulin dependent diabetes mellitus.*

How reliable is the test?

The test will identify about 70 percent of those people destined to develop Type I diabetes.

What can be done if a person's test is confirmed positive?

There are two alternatives:

1) In some cases, the islet cell antibody test will simply identify an indi-

vidual who is just about to develop the disease. Those individuals should be evaluated by their physicians.

2) In others, the islet cell antibody test will identify people with only abnormal antibodies. A more involved battery of tests can be arranged to evaluate the amount of destruction to the insulin producing cells. These people can be re-tested on a regular basis (at least every six months).

How do I arrange for a screening?

If you live close enough, go to either the Joslin Diabetes Center or to Diabetes Clinical Research at the University of California, Davis, Medical Center to fill out the questionnaire and have the blood sample drawn.

To schedule an appointment at the Joslin Center, call (617) 732-2531 or 732-2524 between 10:00 a.m. and noon Monday, Wednesday or Friday. To schedule an appointment at the Diabetes Clinical Research Unit, call (916) 453-8152 Monday through Fri-

day.

If you do not live close enough to either laboratory, please call us to request a list of physicians who have volunteered to collaborate in the collection of blood.

Information and questionnaires can be obtained free by a telephone request or by mail to: Dr. George S. Eisenbarth, Joslin Diabetes Center, One Joslin Place, Boston, MA 02215, telephone: (617) 732-2531; or Dr. J. Stuart Soeldner, Diabetes Clinical Research, 1625 Alhambra Blvd., Suite 2901, Sacramento, CA 95816, telephone: (916) 453-8152.

Do not mail a sample to the Joslin Center until you have obtained a kit and enclosed a completed questionnaire. Allow eight to ten weeks for return of test results.

The questionnaire is important, please fill out all information requested.

Social Security, SSI, and Medicare Facts for 1989

(Note: This article appeared in the February 1989 issue of the *Braille Monitor*, a worldwide publication of the National Federation of the Blind.)

The beginning of each year brings with it some annual adjustments in Social Security programs. The changes include new tax rates, higher exempt earnings amounts, Social Security and SSI cost-of-living increases, and changes in deductible and co-insurance requirements under Medicare. Here are the new facts for 1989:

FICA (Social Security) Tax Rate: The tax rate for employees and their employers during 1988 (effective January 1) was 7.51%. The same rate applies in 1989. The maximum FICA amount to be paid by an employee during 1989 is \$3,604.80, up from \$3,379.50 during 1988. The increase results from a higher ceiling in earnings subject to tax, effective January 1, 1989. The maximum Social Security contribution to be paid by self-employed individuals during 1989 will be \$6,249.60.

Ceiling on Earnings Subject to Tax: Social Security contributions will be paid during 1989 on the first \$48,000.00 of earnings for employees and self-employed persons. This compares to the 1988 ceiling of \$45,000.00.

Quarters of Coverage: Eligibility for retirement, survivors, and disability insurance benefits is based in large part on the number of quarters of coverage earned by any individual during periods of work. Anyone may earn up to four quarters of coverage during a single year. During 1988, a Social Security quarter of coverage was credited for earnings of \$470.00 in any calendar quarter. Anyone who

earned \$1,880.00 for the year (regardless of when the earnings occurred during the year) was given four quarters of coverage. In 1989 a Social Security quarter of coverage will be credited for earnings of \$500.00 for a calendar quarter, and four quarters can be earned with annual earnings of \$2,000.00.

Exempt Earnings: The earnings exemption for blind people receiving Social Security Disability Insurance (SSDI) benefits is the same as the exempt amount for individuals age 65 through 69 who receive Social Security retirement benefits. The monthly exempt amount in 1988 was \$700.00. During 1989 the exempt amount will be \$740.00. Technically, this exemption is referred to as an amount of monthly earnings which does not show "Substantial Gainful Activity." Earnings of \$740.00 or more per month for a blind SSDI beneficiary in 1989 will show Substantial Gainful Activity after subtracting any unearned (or subsidy) income and applying any deductions for impairment-related work expenses.

Social Security Benefit Amounts for 1989: All Social Security benefits (including retirement, survivors, disability and dependents benefits) are increased by 4% beginning January, 1989. The exact dollar increase for any individual will depend upon the amount being paid.

Here are some sample Social Security monthly benefit amounts payable beginning January, 1989: average Social Security retirement check, \$537.00; average benefit for aged couple, both receiving benefits, \$921.00; average benefit for widow or widower and two children, \$1,112.00; average check for disabled workers, \$529.00; average

benefit for disabled spouse and children, \$943.00. The maximum Social Security benefit for a worker who retired in 1988 at age 65 will be \$872.00 in January, 1989, up from \$838.00.

SSI Resource Increase: There is

an annual increase, effective January 1, 1989, in the amount of resources permitted for SSI (Supplemental Security Income) recipients. In 1988, individuals could have resources of \$1,900.00, and couples could have

(Continued on page 9)

Scientists Discover Diabetes Hormone

by Malcolm Rittler (A.P.)

Scientists say they have isolated a hormone that may play a key role in causing the most common form of diabetes, a step that might lead to new treatments.

The hormone appears to be responsible for the obesity, reduced insulin secretion and reduced effectiveness of insulin observed in Type II diabetes, said researcher Garth Cooper.

Currently, obesity is considered a major contributor to the disease rather than a symptom of it.

Cooper, a New Zealand biochemist, is working with researchers at Oxford University. He said the substance, which the researchers named amylin, is normally undetectable but was found in high levels in the pancreases of diabetics.

The work is "a very important finding" if amylin truly blocks insulin and appears in abnormal amounts in diabetics, said F. Xavier Pi-Sunyer, an authority on Type II diabetes.

Scientists already knew of another pancreatic hormone that blocks insulin, but it is not found in abnormal levels in diabetics, said Pi-Sunyer, director of the endocrinology, diabetes and nutrition division at St. Luke's-Roosevelt Hospital Center in New York.

Insulin normally controls the level of blood sugar. In Type II diabetes, also called non-insulin-dependent diabetes, the body's insulin is not effective and blood-sugar levels rise too high.

Complications can include kidney disease, blindness and gangrene, which can require leg and foot amputation.

Type II diabetes afflicts the vast majority of the nation's estimated 11 million diabetics, according to the American Diabetes Association. It often can be controlled through diet and exercise.

The amylin research "opens the door to the scientific study of the disease at a level that wasn't possible before, and potentially the mechanisms that we uncover may be very wide ranging," Cooper said.

He said researchers hope to develop substances that block amylin's secretion or action, opening the possibility of treatment. He also said researchers hope to develop a test to detect diabetes very early in its development.

(Note: This article appeared in *The News-Leader*, Springfield, MO, Dec. 17, 1988.)

Pool Risk Insurance: An Option

by Susan Manchester



Susan Manchester, Vice President and Legislative Committee Chairwoman of the Diabetics Division of the NFB, tells about pool risk insurance.

Assigned Health Pool Risk Insurance is a health care bill which the state of Connecticut was the first to adopt. This plan provides medical insurance coverage for people who are not covered through their work or who can not obtain coverage due to a chronic health condition. This coverage is obtained through a pool of all insurance companies who currently sell health insurance in the state. It is mandatory that the companies participate in the pool if they wish to continue selling health insurance in Connecticut.

The bill providing health care coverage contains a stipulation that the

insured consumer must be a participant in the plan for one full year before a pre-existing illness will be covered. This waiting period may be a negative feature for those with a chronic disease, such as diabetes. In addition, the costs of coverage under this health care plan are \$8,000 per year. A strong point of the bill, though, is that health care can be provided for those people who have no other means of obtaining medical insurance.

The Pool Risk Bill has been introduced in other states besides Connecticut but has failed to pass in approximately 20 states. I am sure that the high cost of this plan is the major barrier. If your state has currently not adopted such a plan, contact your State Insurance Commissioner and check the status of a Pool Risk Insurance Bill. If a plan has already been introduced and failed to pass, then contact your state's legislative body and ask what prevented the passage of the bill. You should offer to work with your legislators on any problems encountered when the Pool Risk Bill was originally introduced, and offer to attend a session to speak in favor of its passage. Since diabetics and others with chronic health conditions will benefit, you should also seek their service in this endeavor.

Please don't hesitate to contact me if I can be of assistance. Susan Manchester, 15 Pine Tree Lane, Apt. 1A, Fairfield, CT 06430; telephone: (203) 333-1365.

The National Federation of the Blind

The National Federation of the Blind is the largest membership organization of blind people in the nation, having chapters in every state and approximately 50,000 individual members. It is the blind speaking for themselves. The National Federation of the Blind seeks to integrate the blind into society so that they are seen as normal, participating citizens—as people you would want to know, to hire, to work with, associate with in clubs and recreation.

We seek to show the public that we are just normal people who cannot see—not helpless and dependent, not blessed with special powers and gifts. We help the newly blinded learn that life can still be good. We show blind children that they can have a meaningful future. With proper training and skills, the blind can take a normal part in society—education, a job, a home, a family, normal recreation (camping, bowling, water skiing), and participation in community affairs.

We help blind persons find jobs—and the confidence to get and keep those jobs. Many willing, capable blind people have never had a job. Seventy

percent of the blind are unemployed. Many of the rest are underemployed.

Our work is in the best interest of every American—our work to reduce blindness from a tragedy to a mere nuisance, our work to help the public accept the blind as normal people, our work to see that blindness does not mean isolation and dreadful loneliness.

How Can I Help?

You can inform yourself about blindness and help inform others. You can write for our literature, and you can get to know blind persons in your community. Blindness can happen to you or to one of your friends or to a member of your family. Don't wait for it to happen before doing something about it. You can begin today.

You can also help by making cash contributions to our organization or remembering the National Federation of the Blind in your will. The National Federation of the Blind is supported by public contributions. Donations are tax deductible and may be sent to:

Treasurer, National Federation of the Blind, 1800 Johnson Street, Baltimore, MD 21230.

A Letter to the Editor



Gerald Scott was diagnosed as a diabetic six years back. He shares his experiences and observations concerning diabetes.

(Note: Following is part of a letter our editor received.)

From: Gerald Scott

Dear Ed,

I have just read an issue of *Voice of the Diabetic* and am impressed. I have sent in my subscription plus a small donation.

Your article about how to use a syringe when one is blind was very interesting. (Editor's Note: The article referred to appeared in *The Voice*, Vol. 3, No. 3.) I have diabetic retinopathy which causes people's mouths to look like they are slanted while I watch television. By looking to one side or out of the side of my eyes, I see the picture correctly.

I do a lot of reading about this affliction. From my reading, I understand that the distortion in my vision is caused by the narrowing of tiny blood vessels.

This situation makes it difficult for me to read the scale on the insulin syringe. It also makes it difficult to pierce the insulin bottle stopper without touching the metal around the rubber. To help with these difficulties, I use the Becton Dickinson Magniguide which is used to insert the needle.

I also can't read the syringe markings which are needed to measure insulin. To get the correct amount of insulin in my syringe, I use chips of plastic or soft metal cut to fit between the tip of the plunger and the syringe body. Using this method, I can fill a syringe with mixed insulins in two minutes.

I feel that more and more diabetics are mixing insulins instead of injecting twice a day. My 7 a.m. shot includes seven units of the fast-acting insulin which goes into action shortly after breakfast and 23 units of the slowest-acting insulin which carries me through until 7 a.m. the following morning with a little overlap.

I have found that having eggs for breakfast always sends me into a low, unless I eat a small helping of some other breakfast food. Using

cheap, large loaves of bread that are puffed up will cause a dip in my blood sugar while using small, expensive loaves of bread will cause a rise.

Now to get into ways of economizing. I use syringes until they get dull, as long as three weeks. I have never gotten a pink spot on the skin from this, but of course, some people may be more sensitive.

The syringes don't have to be sterilized or refrigerated. If the room is unusually warm, I use the refrigerator, but the insulin should never be frozen.

I have read that the best place to inject insulin is the belly, the next best is the legs and the least effective location is the arms. When I inject, I don't use alcohol swabs because I am told that they cause the skin to toughen.

I was diagnosed diabetic about six years ago when I was 76 years old. This diagnosis came after many visits to my doctor, a general practitioner. After a year or so on pills, he told me that I would have to use insulin. He had his nurse show me how to use a syringe.

My doctor told me how much lente insulin to use, but didn't advise the use of a machine to test my blood sugars. I purchased a machine anyway, tested my blood sugars and altered the amounts of insulin that I took. I visited my doctor for advice about once a month.

Today I keep my blood sugar levels between 100 and 150 except for occasional dips. I used to test four times a day for three or four days until the readings were within the limits. Then I would go for as much as three weeks without testing. Now I test my blood sugars more often because I started to wonder if they were higher between meals. I usually retest if my blood sugar level is too low, or if I get a little shaky.

In my approximately six-year experience with diabetes, I have found that there are two types of diabetics: the first one tries to forget it and the second one tries to help other diabetics.

I live in a town of about 15,000, and we have no diabetes specialists, only general practitioners. I have found out that older doctors who do not specialize in diabetes are further behind than I am.

I have read that about one-half of the diabetic population is diagnosed about five years too late. I believe that I am one of them because I developed retinopathy and neuropathy within about a year after being diagnosed as having diabetes. In my case, I think I know why the diagnosis was late. I would always walk the mile between my home and the medical clinic. Since walking or any exercise lowers the blood sugar, just as does insulin, the blood test my doctor made was always lower than it would have been if I had driven my car.

From The Editor

Gerald Scott shows wisdom and insight about diabetes. I know that he is a doer because he found a way to independently measure insulin after losing enough vision so that he was unable to see the markings on an insulin syringe.

Gerald says that he feels "more and more diabetics are mixing Insulins instead of injecting twice a day"; more diabetics are mixing Insulins but, in reality, they are injecting two or more times daily. More and more physicians agree that multiple daily injections keep blood glucose levels in better balance.

Many physicians, but not all, feel that an insulin syringe can be used as long as wanted. When the syringe becomes dull, injections will become more painful. Studies have shown that the preservatives present in Insulin will protect your skin from infection. The syringe needle should be recapped after use, but refrigeration of the syringe does not seem necessary. We can not guarantee that repeated use of disposable syringes and non-refrigeration will prevent skin infections. However, the chances of infection are minimal if the skin is kept clean.

Gerald tells about the best places to inject insulin. It is worthwhile mentioning that if the diabetic will be doing leg exercises, such as jogging, then the leg should not be used for the injections on that day. The insulin will burn up faster.

I checked with one diabetes specialist regarding blood glucose testing, and he recommends to his patients that they check their levels four times daily until their blood glucose is

regulated. After this, his patients should check their levels one day a week, for four checks on that day. Puncturing fingers four times a day on an ongoing basis may lead to soreness. He says that patients who follow his plan will keep their fingers healthy and keep their blood glucose levels in balance. All diabetics should remember that when ill, blood glucose levels should be checked often.

Gerald said that he lives in a small town where no physician specializes in diabetes. There are only general practitioners. It is extremely important that, if possible, all diabetics have a physician that specializes in diabetes. It is important that the doctor know what he/she is talking about. Education about diabetes is vital, especially if the diabetic lives in a community where there are no specialists. There are several good publications which cover all aspects of diabetes, and often hospitals will sponsor classes on these subjects. Diabetics can check with their physicians and/or hospital(s) to find a local diabetes support group.

Gerald Scott is correct when he says that "walking or any exercise lowers the blood sugar just as does insulin." He may be correct in thinking that this is the reason why his diabetes wasn't diagnosed sooner. Often when people are diagnosed as being diabetic, they have had the disease for years, and complications have already begun to develop.

Again, Gerald Scott is to be commended for keeping himself updated about diabetes, asking questions and using alternative techniques to self-manage his diabetes.

Diabetic Needs Some Homework

Dear Dr. Donohue: I have been diagnosed as having diabetes. My blood sugar count is up. My physician tells me I need NO medication. He says I should lose some weight. Do you agree? — M.S.

Your brief and generalized note tells me little, but it does permit the assumption that you haven't done your diabetes homework. Don't feel bad. In fact, it gives me a chance to let other diabetics like yourself in on a couple of basic facts.

No matter how you look at diabetes, the problem lies in an inability of the body's cells to open themselves to the entry of sugar. And that brings us directly around to insulin, the pancreas hormone that acts as the cell "key" for that sugar entry. Without insulin, the sugar hangs around, its level rising inevitably in the blood. That's diabetes.

To fix the lock you have to find out why it jammed. The problem occurs in one of two ways. Either the pancreas doesn't make enough of the insulin key (the hormone) or the body's chemistry is acting against it. Sometimes, the two factors can be combined. When it's the pancreas' production that's at fault, the diabetes is called Type I. When it's the body working against the available hormone, we call it Type II.

You seem to have Type II.

What is causing this foul-up in the cell lock and key mechanism, blocking sugar entry to your cells and making the blood sugar rise? Your doctor has given you the important part of the answer — your weight. Fat works against the action of insulin. And the more weight there is, the worse the problem. Your doctor feels that if you get down to normal weight, the sugar will be able to get out of your blood and into your body cells. If that happens, you may never need medication at all.

So yes, I do agree with your doctor. If you ask him, he'll tell you the kind of weight-loss diet that is best for the diabetic. Basically, it involves distributing your calorie total carefully among food types — 55 percent carbohydrate, 10-15 percent protein, and the rest fat, chiefly polyunsaturates, low on cholesterol.

A final note: While I specified this therapy for most people with your kind of diabetes, I did not mean that weight control was any less important for those who have deficient insulin production to begin with (Type I). Their problem can involve both factors, including the excess body fat. However, most Type I diabetics are thin.

(Note: This Dr. Paul Donohue question appeared on Jan. 22, 1988 in newspapers across the land.)

Nutrition Affects Diabetes

by Leslie Hawk, dietitian
St. Francis Hospital

Almost everything we eat and drink is broken down by the body into glucose, a simple sugar that is carried in the bloodstream. Glucose, also known as blood sugar, provides energy to the brain, eyes, muscle and every other bodily process and function.

In order for the glucose to get from the bloodstream to the cells, insulin has to be present. Insulin is a hormone produced by the pancreas, released after we eat, and allows the sugar to leave the bloodstream and be taken up by the cells for energy use. Insulin, therefore, lowers the amount of sugar in the blood.

Diabetes is a disease that interferes with the normal processes of insulin and blood sugar control. There is no single cause for diabetes and no standard treatment. Treatment of diabetes is individual and specific to the involved person. There are two different types of diabetes depending upon whether your body makes insulin and how it is used.

Type I diabetes, also referred to as insulin dependent diabetes mellitus, or juvenile-onset, occurs in 15 to 20 percent of persons with diabetes. It usually appears before the age of 40 with symptoms including increased thirst, urination and hunger. This type is associated with a total or nearly total loss of the body's capacity to secrete insulin. Insulin therapy, through daily injections, is therefore necessary to control blood sugars. Much attention should be given to the diet,

insulin therapy schedule and exercise so that a more normal life can be led.

Type II diabetes, also called non-insulin dependent or adult onset diabetes, accounts for 85 to 90 percent of people diagnosed with diabetes. People are usually middle-aged and overweight, and the onset is gradual. The body produces insulin, but it may not be enough to carry glucose into the cells. Diet and oral hypoglycemic agents are the preferred choice of treatment to control blood sugar. If there is persistent and uncontrolled hyperglycemia (high blood sugar), then insulin therapy is required. If the person is obese, glucose tolerance improves with weight loss and calorie control. This would hopefully allow patients to gradually be weaned from insulin as they lose the extra weight.

Diet is a central therapeutic measure in the management of diabetes mellitus. *The goals of the diet are:* a nutritionally adequate intake with a calorie level appropriate for the maintenance of desirable weight; the achievement of a consistently normal blood sugar, and the reduction of fat leading to heart disease. Food is chosen daily from six food groups or exchange lists: bread-starch, meat, fruits, vegetables, milk and fat. Other considerations are the consistency and timing of meals, the distributions of calories among meals, the composition of meals, reduction of simple carbohydrates and sugar and diet dullness.

Social Security

(Continued from page 7)

\$2,850.00. These amounts are increased in 1989 to \$2,000.00 for individuals and \$3,000.00 for couples. Resources include checking accounts, savings accounts, cash value of insurance, stocks, bonds, and similar assets. Anyone who was previously denied SSI benefits on the basis of excess resources may reapply if current resources are within the 1989 limits.

Standard SSI Benefit Increase: Beginning January, 1989, the federal payment amounts for SSI for individuals and couples are as follows: individuals, \$368.00 per month; couples, \$553.00 per month. These amounts are increased from: individuals, \$354.00 per month; couples, \$532.00 per month.

Medicare Deductibles and Co-insurance: Medicare Part A coverage provides hospital insurance to most Social Security beneficiaries. The co-insurance payment is the charge that the hospital makes to a Medicare beneficiary for any hospital stay. Medicare then pays the hospital charges above the beneficiary's co-insurance amount. The basic co-in-

surance amount for Medicare Part A was \$540.00 for a hospital stay in 1988. If the hospital stay extended beyond 60 days but not more than 90 days, the co-insurance amount was an additional \$135.00. In 1989, the Part A co-insurance amount is \$560.00. There is no additional co-insurance amount for hospital stays which are longer than 60 days. This is the first major change in Medicare coverage resulting from the "Medicare Catastrophic Coverage Act of 1988." Other changes will be phased in over the next five years.

The Medicare Part B (medical insurance) deductible is \$75.00. The medical insurance premium which Medicare charges for Part B coverage increases, however, from \$24.80 per month to \$31.90 per month. This is the amount withheld from Social Security checks for Medicare Part B coverage. Four dollars of the Medicare premium increase will go to pay for the new catastrophic coverage. The cost-of-living increase for Social Security beneficiaries is greatly reduced by this substantial increase in Medicare premiums. Therefore, many Social Security checks will not be increased very much in 1989 over the corresponding amount of the actual monthly benefit in 1988.



Recipe Corner

Karen Derrick is a registered dietitian at the Veteran's Administration Hospital of Columbia, Missouri. She is an insulin-dependent diabetic who graciously calculates the diabetic exchanges and food values for our recipes.

Send your great ideas to the editor. He is the official taste tester and needs recipes to test his taster.

Lemon Garlic Chicken Thighs

Submitted by Frances Allen
from Columbia, MO

8 chicken thighs
juice of 1 lemon
1 clove garlic, crushed
½ tsp. dried thyme leaves
white pepper
10 cherry tomatoes
2 Tbs. butter or margarine

Wash and pat dry chicken. Put chicken in a bowl. Toss the thighs with a mixture of the lemon juice, crushed garlic and thyme. Make sure all sides are coated. Refrigerate chicken for 2 hours or more — turn pieces at least once. Place thighs on a rack in the baking pan, skin side up. Sprinkle with salt and pepper. Bake at 425°F for about 30 min. Halve cherry tomatoes. Melt butter in a skillet. Add tomatoes. Cook 1 to 2 min. to heat thoroughly. Put chicken on serving platter. Spoon on sautéed tomatoes. Serve immediately.

Yield: 4 servings; Calories: 350;
Diabetic Exchanges: 4 meat, 1½ fat.

California Coleslaw

Submitted by Frances Allen
from Columbia, MO

1 small head cabbage, shredded
1 small white onion, chopped
1 green pepper, chopped
1 red pepper, chopped
1 small carrot, grated
3 Tbs. minced parsley
Dressing:
½ cup cider vinegar
3 Tbs. sugar substitute
½ tsp. salt
¼ tsp. white pepper
½ cup salad oil

Combine cabbage, onion, green and red peppers, carrot and parsley. Toss to mix. Combine the vinegar, sugar, salt, pepper and oil in a jar or shaker. Shake to blend. Pour mixed dressing over slaw. Cover and chill. Gently toss at serving time.

Yield: 4 servings; Calories: 290;
Diabetic Exchanges: 2 veg, 5 fat.

Oatmeal Cookies

Submitted by Linda Carstens
from Virginia, MN

½ cup margarine
½ cup oil
1 soup spoon Sweet-10 (artificial sweetener)
½ bottle low calorie syrup (Diamel)
2 eggs
2 tsp. vanilla
2 cups flour
1 tsp. cinnamon
½ tsp. allspice
½ tsp. nutmeg
1 tsp. salt
1 tsp. baking soda
1 tsp. baking powder
2 cups oatmeal
1 cup cold coffee

Drop by spoonful on cookie sheet. Bake at 375° for about 12 to 15 minutes. Keeps best in refrigerator. Raisins can be added.

Yield: 24 large cookies; Calories: 150 for 1 cookie;

Diabetic Exchanges: 1 starch/bread plus 2 fats; 2 cups raisins = 1 fruit.

Watch Out for Microwave Popcorn

Most packaged microwave popcorn contains a hefty dose of sodium and as much fat (partially hydrogenated soybean, cottonseed and coconut oil) per ounce as most cookies, along with more than twice as many calories as conventional popcorn.

(Make your own popcorn by other methods and control fats and salt.)

(Note: This appeared in *Common Concerns*, a publication of the Consumer Committee of the Renal Network of the Upper Midwest.)

Self-help Treatment for Diabetes Lists Exercise

NYU Medical Center

Exercise is an important part of self-treatment for diabetes and should be embarked upon thoughtfully, according to a physician at New York University Medical Center.

"Regular exercise can significantly benefit people with diabetes by lowering blood-sugar levels, decreasing cholesterol levels and improving cardiovascular tone — all vital components of treatment," said Dr. Andrew J. Drexler, assistant professor of clinical medicine at the center. "However, exercise requires changes in other aspects of self-care and requires self-monitoring of blood glucose."

Diabetes is a disease in which the body does not properly utilize glucose, a form of sugar. Glucose, therefore, can build up to abnormally high levels in the blood. Exercise increases the rate at which glucose is used by muscles, and so tends to lower blood-sugar levels.

"People who have diabetes should check their blood-sugar levels at home regularly," Drexler said. "If the level changes, they should find out why — whether it is due to diet, medication or a new exercise program — and correct the problem."

For example, as muscle use of glucose increases due to exercise, the liver responds by increasing its glucose output into the blood to re-establish equilibrium — and may overshoot. As a result, a paradoxical reaction sometimes can occur, especially in people whose diabetes has

not been well controlled; temporarily, there may be a net increase in blood-sugar level upon starting an exercise regimen.

Although exercise poses no special risks for most people with diabetes, any diabetic person should have a thorough physical checkup prior to starting a new program to search for other possible problems, such as heart disease.

In addition, people who have some complications of the disease need to be particularly careful and exercise only under supervision. For example, those who have diabetic neuropathy — a nerve disorder that can cause lowered sensitivity of the feet — can develop foot injuries but not feel any pain. And those who have diabetic retinopathy, an eye disorder, can develop eye damage if blood pressure rises excessively; they should avoid isometric exercises such as weightlifting, which tend to raise blood pressure.

"In general, exercise can be an integral part of the care of diabetes," Drexler said. "Beyond its physical benefits, success in exercise and sports can help people with diabetes feel more in control and enhance their self-image."

(Note: This article appeared in the *Rapid City Journal*, Rapid City, SD, Sept. 1, 1987. Although this information was published over a year ago, the information is still accurate.)

My NovolinPen

by Annie Weems



Annie Weems, co-chair of the Aids and Appliances Committee, Diabetes Division of the NFB, tells how she self-manages her diabetes as a blind person.

I have owned a NovolinPen since October of 1988. It was given to me by my diabetic specialist since she felt that it would benefit me due to my poor eyesight. The NovolinPen is an insulin injection device which looks like a fountain pen — it even has cartridges like a fountain pen, but these cartridges contain insulin.

What I truly love about it is the fact that I no longer have to measure insulin; my NovolinPen does that for me. The NovolinPen is designed for accurate delivery of two units to 36 units of insulin in two unit increments. The NovolinPen uses a cartridge called a Novolin PenFill that holds the insulin. There are three types of pen fills: Novolin R, Novolin N and a pre-mixed Novolin 70/30 PenFill (70 percent NPH Human Insulin Isophane Suspension and 30 percent Regular Human Insulin Injection, semi-synthetic). Each PenFill contains 150 units of insulin. At the end of the pen is a dial and with each turn, it clicks to release two units of insulin. The locking ring needs to be twisted one-fourth turn to the locked position. The insulin is now ready to be injected. The injection technique recommended by your physician should be used. The NovolinPen has a button that injects the insulin when pushed. After the injection, the locking ring should be returned to the unlocked position. The NovolinPen fits easily into pocket, purse or briefcase.

I know that I would not be able to do without the NovolinPen now that it has been in my life for such a short time.

Denver Presbyterian Dialysis Center, 1719 E. 19th Ave., Denver, CO 80218; phone: (303) 839-6111; Contact: Maintenance Manager Marie Zrust; taxi fare: \$3.20.

(Continued from page 11)

Porter Memorial Dialysis, c/o Porter Memorial Hospital, 2525 South Downing, Denver, CO 80210; phone: (303) 778-5703; Contact: Sally Pez-zoli; taxi fare: \$8.40.

Hear Ye Hear Ye A Raffle

The Diabetes Division of the National Federation of the Blind (NFB) reaches out and provides support and information to many people. This valuable networking costs money, such as the production cost for *Voice of the Diabetic*, and we must generate funds to help cover these costs.

Our Diabetes Division board has elected to hold a raffle which will be coordinated by the capable Bill Parker. The grand prize will be \$300.00 and the winner's name will be drawn at this year's annual convention of the National Federation of the Blind on Saturday, July 8, 1989, in Denver, CO. The cost of each raffle ticket is one dollar, or a book of six may be purchased for five dollars.

Tickets may be purchased from state representatives of our Diabetes Division or contact raffle chairman Bill Parker, 857 Ingleside Rd., Norfolk, VA 23502; phone (804) 683-8003. Orders may also be placed through our editorial office: *Voice of the Diabetic*, 811 Cherry Street, Suite 306, Columbia, MO 65201; phone: (314) 875-8911.

Please make all tax deductible checks payable to the National Federation of the Blind. This raffle is open to everyone and raffle participants need not be present at the drawing to win.

Dog Days

A dog is a man's best friend. And it should be.

Consider: I work hard everyday. I work like a dog. That's the reason I'm always dog-tired. But he never works hard. He's lazy as a dog.

When I go out on a date, I always put on the dog. If I owe people money, they dog my footsteps.

In times of conflict, the dogs of war are unleashed. Meanwhile, those who are young have puppy love. There are bird dogs, watchdogs, hot-dogs and under dogs. And when I'm feeling oppressed, I say I lead a dog's life.

Plan Ahead and Be Prepared

At this year's National Convention of the National Federation of the Blind there will be many in attendance who are insulin dependent diabetics. Each of us should have foresight and bring extra insulin and syringes so as to avoid taking time out to go in search of a pharmacy. It might be that the State of Colorado requires a doctor's prescription for insulin and syringes, and if so we would then have the added expense of a physician's visit.

We insulin dependent diabetics should always be prepared in case of an insulin reaction. At a national convention the hotels are jammed with people and the restaurants are usually packed.

At every convention there are a

few diabetics who undergo hypoglycemic attacks which, of course, can be avoided. THINK AHEAD! Always carry something sweet such as candy or glucose tablets that can be used for insulin reactions. We should be sure to have, in our rooms, snack foods that will help control our diabetic food needs.

We diabetics can travel anywhere and do almost anything we want. One thing we cannot do is to go without food.

Our bloodstreams should have a balance of insulin and glucose. If there is not enough glucose (food) then we have an "insulin reaction."

"Plan ahead and be prepared."

Elections Coming Up

At this year's National Convention in Denver, CO elections will be held to fill divisional board positions. These are one-year terms that will run from July 1, 1989 to June 30, 1990. Positions to be filled are: President, First Vice-President, Second Vice-President, Secretary, and Treasurer. If you are interested in a board position, or know someone who you think would do a good job, then contact Karen Mayry. Yes, hard work and dedication are prerequisites of each board position. Anything worthwhile is usually challenging and requires hard work. Leadership should be a positive force, and one should lead by good example.

Convention Display Table

The Diabetes Division of NFB will have a display table in the exhibit hall at the Radisson Hotel Denver. Literature will be distributed, aids to assist the blind diabetic in self-managing his disease shown and explained, and information disseminated.

We are looking for volunteer work-

ers for this year's display table. If you can participate please notify Display Chairman, Bill Parker, 857 Ingleside Road, Norfolk, VA 23502; phone: work (804) 623-8003, home (804) 455-6013.

Hotline Numbers

Following are hotline numbers so you can obtain free medical information and keep up-to-date on the latest research:

1. *Blindness and Physically Handicapped Available Programs*: The National Library Service for the Blind (part of the Library of Congress); phone toll-free: 1-800-424-8567; in Washington, D.C.: (212) 287-5100.

2. *Diabetes*: The American Diabetes Association (ADA); phone toll-free: 1-800-232-3472; in Virginia: (703) 549-1500.

3. *Diabetes*: Juvenile Diabetes Foundation; phone toll-free: 1-800-223-1138; or in New York: (212) 889-7575.

4. *Heart Disease*: Heartline. Sponsored by the Association of Heart Patients; phone toll-free: 1-800-241-6993.

5. *Kidney Disease*: The American Kidney Fund; phone toll-free: 1-800-638-8299; in Washington, D.C.: (301) 986-1444; in Maryland: 1-800-492-8361.

6. *Surgery*: Second Opinion Hotline. Sponsored by the U.S. Government Department of Health and Human Services; phone toll-free: 1-800-638-6833; in Maryland: 1-800-192-6603.

7. *Drugs*: Drug Interaction, Drug Side Effects. Food and Drug Administration (FDA). Center for Drugs and Biologics. Office of Consumer and Professional Affairs, Rockville, MD; phone: (301) 443-1016.

Vision Foundation

We have been asked to announce: This location produces a resource list for blind people. They have resource listings for all blind consumers, not just diabetics. Listings are formatted in braille, cassette, disc record, large print and standard print.

A cassette giving resources is available to blind diabetics. The cost is \$2. Order from Vision Foundation, Inc., 818 Mt. Auburn St., Watertown, MA 02172; phone: (617) 926-4232; in Massachusetts, toll free: 1-800-852-3029.

A Tip

Denise Bradley, a Type I diabetic, says that visual impairment doesn't prevent her from self-managing her diabetes. She says, "I put a piece of clear scotch tape around the label of new bottles of insulin. This is to prevent the large letter identifying the type of insulin from being faded by the frequent rolling of the bottle to mix insulin before filling up a syringe. I can easily read the large letter since it remains nice and clear thanks to the tape."

Don't Forget

Just a reminder to all Diabetes Division members of the NFB, please don't forget to send your annual dues (\$2) to *Voice of the Diabetic*, 811 Cherry St., Suite 306, Columbia, MO 65201. Make checks payable to National Federation of the Blind.

The \$2 annual fee is for membership in the Diabetes Division of the NFB. Members are entitled to a free magazine subscription. It costs about \$8 yearly per subscription to produce *Voice of the Diabetic*, and we ask that, if possible, our members help pay for our publications. All donations are accepted and very much appreciated.

Subscription/Donation/Membership Form

Although the \$2.00 annual membership fee of the Diabetes Division of the National Federation of the Blind (NFB) entitles you to a year's subscription to *Voice of the Diabetic*, production cost per annual subscription of the *Voice* is about \$8.00. For this reason, we must charge all non-members, health professionals and institutions \$8.00 for an annual subscription. Of course, all donations are accepted and very much appreciated.

If you wish to become a member of the Diabetes Division of NFB and receive a free subscription, subscribe as a non-member, or make a donation to the Diabetes Division of NFB, please check the appropriate box or boxes below:

- ☐ I would like to become a member of the Diabetes Division of the NFB and receive a free subscription to *Voice of the Diabetic*:
- ☐ in print ☐ on cassette tape* ☐ both in print and on cassette tape* (\$2.00)
- *Cassette tapes are provided to the blind at no extra cost.
- ☐ I am a non-member or health professional who would like to receive *Voice of the Diabetic*.
(Also institutional rate) (\$8.00)
- ☐ I would like to make a tax-deductible contribution of \$_____ to the Diabetes Division of the NFB.
- Please print clearly.
- Name _____
- Address _____
- City _____ State _____ Zip _____
- Telephone Number (_____) _____

Send this form or a facsimile along with your check to our editor:

Ed Bryant, 811 Cherry St., Suite 306, Columbia, MO 65201

Please make all checks payable to the NATIONAL FEDERATION OF THE BLIND.